3 Durable Medical Equipment Guidelines

3.1 Introduction

3.1.1 General Policy

The Durable Medical Equipment (DME) vendor provides medical equipment, supplies, and services.

The DME provider may also be a qualified Medicaid provider for pharmacy services, but only a DME provider number can be used to bill for DME and disposable medical supplies.

This section covers all Medicaid services provided by DME providers as deemed appropriate by the Department of Health and Welfare. It addresses the following:

- Claims payment.
- Prior authorization (PA).
- Claims billing.
- DME policy
- Medical supplies policy
- Medical equipment and supplies HCPCS codes.
- Oxygen policy.
- Prosthetics and orthotics policy.
- Waiver Services.

3.1.2 Payment

Medicaid reimburses DME services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. Medicaid bases pricing on the DME Medicare Administrative Contractor (DME MAC) pricing for national HCPCS codes.

3.1.3 Healthy Connections (HC)

Check eligibility to see if the participant is enrolled in HC, Idaho Medicaid's primary care case management (PCCM) model of managed care. If a participant is enrolled, a referral from the HC physician is required before payment will be made.

See *Section 1.5 Healthy Connections (HC) General Provider & Participant Information,* for more information.

3.1.4 Medicare and Medicaid

Providers must enroll with the Idaho Medicaid Program separately from Medicare.

If the participant is dually eligible for Medicare and Medicaid, claims submitted to Medicare through the DME MACs are electronically crossed over to Medicaid. Consult the *DME MAC Region D Supplier Manual,* for procedure codes and billing instructions.

3.1.5 Place of Service (POS) Codes

Enter the appropriate numeric code in the POS box on the CMS-1500 claim form or in the appropriate field of the electronic claim. Not all DME procedure codes are payable at all POS locations.

11 Office

12 Home (includes residential care facility)

24 Ambulatory surgical center

33 Custodial care facility

34 Hospice

54 Intermediate care facility/mentally retarded (ICF/MR)

56 Psychiatric residential treatment center

71 Public health clinic

72 Rural health clinic

3.1.6 Program Abuse

Providers are required to follow the rules in *IDAPA 16.03.09 Medicaid Basic Plan Benefits.*

Medical equipment and supply items used by or provided to an individual other than the participant for which the items were ordered is prohibited.

Idaho Medicaid has no obligation to repair or replace any piece of durable medical equipment or supply that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the item.

Program rules and regulations are strictly enforced and violators are subject to penalties for program fraud and abuse.

3.2 Durable Medical Equipment and Supplies Policy

3.2.1 Overview

Idaho Medicaid will purchase or rent medically necessary DME and supplies for eligible participants residing in community settings. Medicaid will also purchase or rent equipment and supplies provided as a part of a home health agency plan of care.

DME is defined as the following:

- Equipment other than prosthetics or orthotics which can withstand repeated use.
- Is primarily used to serve a medical purpose.
- Is generally not useful to a person in the absence of an illness or injury.
- Is appropriate for use in the home.
- Is reasonable and necessary for the treatment of an illness or injury.

Note: Durable medical equipment through a hospice provider is not a covered benefit for Medicaid Basic Plan participants.

While a participant is an inpatient of a hospital, nursing facility, or ICF/MR facility, items included in the *per diem* payment are billed directly to the facility. DME or medical supplies cannot be billed to Medicaid for these participants. Only items that are customized for a specific participant, such as prosthetics and orthotics, may be billed separately to Medicaid. Wheelchairs are separately payable for participants in ICF/MR facilities.

Prior authorization for DME must be obtained even if the participant has other third party insurance, except if the primary insurance is Medicare.

Additional information about DME MACs guidelines are available online at: **www.noridianmedicare.com** or **www.dme.idaho.gov**.

3.2.2 Billing Procedures

Claims are billed to Medicaid on the CMS-1500 claim form or electronically using the HIPAA compliant 837 transaction. Use the appropriate HCPCS procedure codes with each claim. Medicaid uses the same HCPCS codes and modifiers that are used by Medicare. Refer to the *DME MAC Manual* for updated HCPCS codes at: **www.noridianmedicare.com**.

3.2.3 Documentation Requirements

The vendor is required to obtain all medical necessity documentation prior to providing and billing for DME and supplies. Documentation must be kept on file for five years after the date of service.

Documentation must include all of the following:

- The participant's medical diagnosis and description of the current medical condition that requires the equipment or supplies.
- Estimation of the time period (dates) the medical equipment or supply item will be needed and the frequency of use. As needed (PRN), orders will not be accepted without instructions on how/when the medical equipment or supplies will be used.
- For medical supplies, the description and quantity of the supply needed per month.
- A full description of the medical equipment requested. All modifications or additions to basic equipment must be documented in the attending physician's prescription.
- The original physician's dated signature ordering the equipment and supplies and verifying that all of the above information is accurate and correct is required before billing.

- Medical necessity documentation as required by IDAPA 16.03.09.751Durable Medical Equipment And Supplies – Participant Eligibility through 756, Durable Medical Equipment and Supplies –Quality Assurance. These rules are available online at: **http://adm.idaho.gov/adminrules/rules/idapa16/0309.pdf**

3.2.4 Prior Authorization (PA) Procedures

To discover which DME products require PA, access the fee schedule on the Medicaid DME Web site. If an item requires PA, it is specified in the fee schedule. You may also call EDS at: **(800) 685-3757 (toll free) or (208) 383-4310 in the Boise calling area**, to inquire if a HCPCS code requires prior authorization or for the reimbursement amount for a code.

The following rules apply to requests for DME or supplies from DME providers that require prior authorization:

- A PA is a written, faxed, or electronic approval from DHW that permits payment or coverage of a medical item or service that is covered only when authorized by DHW.
- Medicaid payment will be denied for the medical item or service, or portion thereof, which was provided prior to obtaining authorization.
- The provider may not bill the Medicaid participant for equipment and/or supplies not reimbursed by Medicaid solely because the prior authorization was not obtained in a timely manner.
- An exception may be allowed on a case-by-case basis where, despite efforts on the part of the provider to submit a timely request or events beyond the control of the provider prevent it. An explanation of the delay in submission must accompany the request.
- Equipment and/or supplies for an individual will be deemed prior approved if the individual was not eligible for Medicaid at the time these items were approved, but was subsequently found eligible pursuant to *IDAPA 16.03.05.051.03*; and the medical item or service provided is approved by DHW by the same guidelines that applies to other prior authorization requests for medical necessity; and the request was submitted within 30 days of the date the provider became aware of the individual's Medicaid eligibility.
- A valid PA request is defined as a request from a Medicaid provider of medical equipment and supplies that contains all information and documentation as required by rules to justify the medical necessity, amount and duration for the item(s) or service.
- For items that must be manually priced (there is no set price on file), pricing documentation must be attached to the PA request. Incomplete prior authorization requests will be denied. If a request has been denied and if there is additional documentation to support the request, a new request form and all required documentation can be submitted.
- A copy of the Idaho Medicaid DME/Supplies Request form is available in *Appendix D; Forms.* It can be duplicated as needed. If a request has been denied, a new request form and all required documentation can be submitted if there is additional documentation to support the request.
- See *Section 3.2.3 Documentation Requirements* for documentation elements required.
- Medical necessity documentation must show that the participant meets the criteria set forth in the *DME MAC Supplier Manual* (incorporated into Medicaid rule by reference) at: **www.noridianmedicare.com**. Select *Durable Medical Equipment*; select *Supplier Manual* under the News and Publications section. Coverage criteria are in Chapters 3 and 4.
- For those items that do not have criteria in the *DME MAC Supplier Manual*, submit documentation from the physician, therapist, etc. that documents the medical necessity of the equipment for the participant. If less costly equipment was considered and ruled out, the documentation should identify the equipment and the reasons it would not meet the minimum medical needs of the participant.
- Urgent, requests for equipment and supplies required for discharge from the hospital or instances such as supplies for IV antibiotics may be faxed and marked, *urgent* on the top of the request form.

Call the DME Unit at: **(866) 205-7403 (toll free)** to notify staff of the incoming request. For urgent equipment and supplies that required dispensing on the weekend or holiday or after business hours, the DME Unit must receive the request the next business day. A screen print of the decision will be faxed to the provider the same business day the request was received.

If PA is required, the PA number must be indicated on the claim or the claim will be denied.

See *Section 2.3.2 Medicaid Prior Authorization (PA), General Billing Information,* for more information.

3.2.4.1 Where to Send Requests for Prior Authorization

Send or fax requests for PA to:

Division of Medicaid
Attn: DME Specialist
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax: (800) 352-6044

Note: If you fax an *urgent request*, please call and notify DME.

3.2.5 Purchase, Rental, and Warranty Policy

3.2.5.1 DME Rent/Purchase Decision

All durable medical equipment that requires prior authorization for purchase also requires prior authorization for rental.

Rental payments, including intermittent payments, will be applied toward the purchase price of the equipment. The equipment will be considered purchased after the tenth (10th) monthly rental payment except those items such as oxygen and ventilators that are continuous rental. Medicaid follows the payment categories in the DME MAC Supplier Manual.

The Department of Health and Welfare may choose to continue to rent certain equipment without purchasing it. Such items include, but are not limited to apnea monitors and ventilators. The total monthly rental cost shall not exceed one-tenth of the total purchase price of the item.

Monthly rental payments include supplies, when so designated in the DME MAC Supplier Manual, and a full service warranty. Supplies, routine maintenance, repair, and replacement are the responsibility of the DME provider during the warranty period and for continuous rental equipment.

3.2.5.2 Warranty Requirements

Payment will not be made for the cost of materials covered under the manufacturer's warranty. If the warranty period has expired, the provider must have documented on file the date of purchase and warranty period.

Medicaid requires the following minimum warranty periods:

- The power drive of a wheelchair will have a one-year warranty.
- An ultra light or high strength lightweight wheelchair will have a lifetime warranty on the frame and crossbraces.
- All other wheelchairs will have a one-year warranty.
- All electrical components and new or replacement parts will have a six-month warranty.
- All other DME not defined above will have a one-year warranty period.

If the manufacturer denies the warranty due to user misuse/abuse, this information must be supplied when requesting approval for repair or replacement.

3.2.6 Covered Equipment

The following items are covered by Medicaid when medically necessary and the least costly means of meeting the participant's medical need. Medical equipment for purchase must be new when dispensed. This includes equipment that is issued as a capped rental. This does not apply to short-term rental equipment. Used equipment may only be dispensed and reimbursed when authorized by DHW as used.

For items that are covered by Idaho Medicaid, but not by Medicare, refer to the list below for coverage criteria. Check the Idaho Medicaid DME Web site (in the fee schedule) or call EDS to verify whether the item/code requires PA.

Items not listed may be submitted for PA and reviewed for medical necessity by DHW. Prior authorization by DHW may require additional documentation beyond what is required in *Section 3.2.3 Documentation Requirements*.

- Medicaid covers the following DME items. Items marked with **PA** require prior authorization:
- **PA** Apnea monitors (with recording feature), if:
  - There is current documentation of apneic episodes.
  - For renewal, include documentation (download) of the last apneic episode during the last two months. Apnea monitors are not covered for bradycardia or if the only indication is a sibling with SIDS.
- Bath benches/chairs.
- Bathroom grab bars adjacent to the toilet and bathtub.
- Bilirubin lights:
  - To treat for hyperbilirubinemia in an infant/child.
  - PA required after 14 days.
- **PA** Bi-PAP.
- Breast pumps (requires prior authorization after the first 60 days), if the following criteria are met:
  - Child and mother are separated more than 24 hours due to surgery or hospitalization.
  - Child has dysfunctional sucking due to prematurity, Down's syndrome, cleft lip/palate, or craniofacial anomaly.
  - Mother is on short-term medication contraindicating breastfeeding.
  - Mother has mastitis.

    Note: Authorization should be for the participant who meets the criteria (mother or baby). Can be authorized under the mother' when the infant is hospitalized.
- Commode chairs and toilet seat extenders.
- **PA** Communication devices.
- **PA** Continuous Positive Airway Pressure (CPAP) machines.
- Crutches and canes.
- Electric or hydraulic lift devices designed to transfer a person to and from bed to wheelchair or bathtub; or a lift mechanism for a chair; but excluding devices attached to motor vehicles and wall-mounted chairs which lift persons up and down stairs.
- **PA** Equipment for the treatment or prevention of decubitus ulcers, such as overlays or special mattresses. Check to see if the Group One device requires prior authorization. Group Two devices **require** PA. A Group One device must be tried and failed before requesting PA of a Group Two device.

- Equipment used for home dialysis including necessary water treatment equipment.
- Glucose testing devices.
- **PA** Glucose monitor, voice synthesized.
- Hand-held showers.
- Home traction equipment.
- Hospital bed (manual), mattresses, trapeze bars, and side rails.
- **PA** Hospital bed, semi-electric. Semi-electric hospital beds may be rented or purchased when all of the following circumstances are met:
  - The physician identifies the participant as unable to operate a manual hospital bed.
  - The participant resides in an independent living situation where there is no one to provide assistance with a manual bed for the major portion of the day.
  - The participant is unable to change position as needed without assistance, per DME MAC coverage criteria.
- **PA** Insulin Pumps.
- Infusion pumps, external ambulatory infusion or implantable.
- Intravenous infusion, gastric, or nasogastric feeding pumps.
- IPPB machines and nebulizers.
- **PA** Maternity abdominal supports. If the participant has any of the following:
  - Vulvular variscosities.
  - Perineal edema.
  - Lymphedema.
  - External prolapse of the uterus or bladder.
  - Hip separation.
  - Pubic symphysis separation.
  - Severe abdominal or back strain.
  - Medically necessary protective headgear.
  - Nebulizers.
- **PA** Neuromuscular electric stimulators only when nerve supply to the muscle is intact.
- **PA** Osteogenesis (bone growth) stimulator.
- **PA** Oximeters. Requires oxygen saturation documentation and physician's order must include continuous or spot check monitoring. Renewal requires oxygen saturations and oxygen liter flow adjustments required during the covered period.
- Oxygen concentrators and tanks/stationary and portable.
- Orthotics. Check for age limitations on Ankle Foot Orthotoses.
- Pacemaker monitors.
- Percussors, manual or electric.
- **PA** Power operated vehicles.

- **PA** Prosthetics. Some require PA; verify HCPCS code with EDS at (**800) 685-3757 (toll free)** or **(208) 383-4310 in the Boise calling area.**
- Suction pumps.
- **PA** Transcutaneous electric nerve stimulators (TENS) when proven effective for acute postoperative or chronic intractable pain only when more conservative treatment modalities have failed.

  Note: Documentation is required and the effectiveness must be documented by the physician following a maximum trial period of two months.
- Transfer boards.
- **PA** Ventilators. Diagnoses and conditions requiring ventilator assistance are: COPD, polio, amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophy, emphysema, bronchitis, musculoskeletal disorders, phrenic nerve damage, spinal cord injuries, multiple sclerosis, congenital trauma, or osteogenesis imperfecta.
- A ventilator is authorized only when a CPAP or Bi-PAP has been proven ineffective or is not appropriate for the medical condition of the patient.
- Walkers with hand brakes require prior authorization.
- Wheelchairs are limited to one wheelchair per participant no more than once every five years when Medicare DME MAC criteria are met and the requested wheelchair is the least costly to meet the participant's minimum medical necessity needs.

  Note: Requests for purchase of a wheelchair require a written physical therapy or an occupational therapy evaluation that documents the appropriateness and cost-effectiveness of the wheelchair and accessories and its ability to meet the participant's long-term medical needs. Requests for wheelchair rentals under three months do not require a physical therapist or an occupational therapist evaluation if the need is self-limiting (e.g. fractured femur). Additional months may require a physical therapist or occupational therapist evaluation.

  Note: Items marked with PA require PA. Any supplies not listed may require PA. Check the DME Website or call EDS at: **(800) 685-3757 (toll free)** or **(208) 383-4310 in the Boise calling area**, to verify if a code requires PA.

3.2.6.1 Wheelchair Repairs

The Department of Health and Welfare (DHW) or its designee may prior authorize wheelchair repairs or parts replacements including, but not limited to, tires, footplates, seating systems, drive belts, and joysticks. Repairs or replacement of any of the above items will not be authorized more than once every 12 months.

Specially designed seating systems for wheelchairs may be replaced no more than once every five years. Seating systems for participants in growth stages must provide for system enlargement without complete system replacement.

3.2.7 Covered Medical Supplies

No more than a one month supply of necessary medical supplies can be dispensed per calendar month. The physician's order must indicate the type and quantity or frequency of use. The participant must request a refill of supplies before they are dispensed.

Note: Quantities in excess of those in the *DME MAC Supplier Manual* require PA.

Medicaid covers the following supplies:

- Catheter supplies including catheters, drainage tubes, collection bags and other incidental supplies.
- Cervical collars.

- C-Pap and Bi-Pap supplies.
- Colostomy and urostomy supplies.
- Disposable drug delivery system.
- Disposable supplies required to operate approved medical equipment such as suction catheters, syringes, saline solution, etc.
- Disposable underpads (limit of 150 per month).
- Dressings and bandages to treat wounds, burns or provide support to a body part.
- Fluids for irrigation.
- Gloves (for patient care only). If diagnosis is not ESRD, Medicare does not have to be billed first.
- Incontinence supplies for persons over four years of age including, disposable diapers/briefs/pull-ups, etc. Limit 240 per month. Disposable wipes are not covered.
- Injectable supplies including normal saline and Heparin but excluding all other prescription drug items.
- Blood or urine glucose monitoring materials (tablets, tapes, strips, etc.)
- Oxygen (gas or liquid) for participant-owned systems.
- Peak flow meter.
- Spacer for metered dose inhaler.
- Gradient Compression stockings. Limit of two pair of stockings every four months if required for both legs. Limit of two stockings every four months if needed for one leg.

3.2.7.1 Oral, Enteral, or Parenteral Nutritional Products, Equipment, and Supplies

Oral, enteral, or parenteral nutritional products do not require prior authorization. However, the vendor must obtain and keep the following documentation on file for five years after the date of service:

- Physician's order and documentation of medical necessity
- A nutritional plan, which must include appropriate nutritional history, the participant's current height, weight, age, and medical diagnosis. For participants under age 21, a growth chart including weight or height percentile must be included.

The plan must include goals for either weight maintenance or gain. If the medical necessity is a nutritional supplement, the plan must outline the steps to decrease the participant's dependence on the continued use of nutritional supplements.

The schedule for reviewing and updating the nutritional plan will be determined by individual needs, but at least annually, and must be approved by the physician.

Nutritional products will be paid in accordance with HCPC code description: 100 calories equals one unit. (See Enteral Product Classification list at: **www.noridianmedicare.com**.)

On the claim, include:

- The number of calories per day ordered by the physician.
- Number of calories per can in the comments (field 19).

Attach a copy of the invoice dated just prior to the date of service.

In the narrative field on the claim, indicate whether or not the participant is taking nutritional products orally. Medicare does not have to be billed first if the product is administered orally.

Thickener is covered when medically necessary for use with oral nutrition.

Traditional infant formulas are not covered.

Product classification for certain DME can be found online at: **www.noridianmedicare.com**.

3.2.8 Non-covered Equipment and Supplies

The following are not covered under the DME program:

- Services, procedures, treatment, devices, drugs, or application of associated services that DHW or its designee considers investigative or experimental on the date the services are provided.
- More costly services or equipment when less costly, equally effective services or equipment is available, as determined by DHW or its designee.
- Any service specifically excluded by statute or administrative code.
- Non-medical equipment and supplies and related services.
- Items for comfort, convenience or cosmetic purposes, e.g., wipes, peri-wash, exercise or recreational equipment, etc.

Product classification for certain DME can be found online at: **www.noridianmedicare.com**.

3.2.9 Procedure Codes

All claims must use the appropriate HCPCS codes when submitting a claim for payment.

3.2.10 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Equipment

The following DME and supplies may be covered for a child through the month of their 21st birthday under EPSDT when medically necessary and the least costly means of meeting the medical need:

- Certain therapy equipment such as therapy mats, therapy balls.
- Wheelchair tie down restraints.
- Personal and comfort items:
    - Toothettes for children who require oral stimulation or have severe spasticity or a deformity in the mother which prevents proper cleaning using a regular toothbrush, waterpiks, or periodontal devices.
    - Eating/feeding utensils, such as rocker knives, special plates with rims.
    - Page turners.
    - Reachers.

Prone Stander: The following needs must be identified by a physical therapist and ordered by a physician (limited to no more than once every five years):

- Stretching of heel cords.
- Prevention of hip dislocation.
- Improvement of bone density.
- Weight bearing to enhance muscle development.
- Transition to standing/help with transfers.

Gait Trainer: The following needs must be identified by a physical therapist and ordered by a physician (limited to one every five years):

- Promote gross motor development.
- Promote independent mobility.

- Initiate stepping.

Specialized Bath Chair: The following must be identified by a physical therapist and ordered by a physician (limited to one every three years):

- Difficulty in bathing due to size.
- Decreased tone/insufficient trunk control.
- Inability to sit independently.
- Need for head and trunk support during bathing.

Specialized Toilet Seat: (Limited to children over four years of age.) The following needs must be identified by a physical therapist and ordered by a physician (limited to one every three years):

- Inability to sit without support.
- Decreased tone/insufficient trunk control.

Specialized Car Seat: (Limited to children over four years of age.) The following needs must be identified by a physical therapist and ordered by a physician (limited to one every five years):

- Proper positioning which cannot be met by a regular car seat.
- Insufficient trunk control/trunk support.
- Decreased muscle weakness/tone; and alternative is to take the child in the vehicle lying down or sitting without needed support.
- Requires support of the head during transport.

3.2.11 Oxygen Services

3.2.11.1 Overview

Medicaid will provide payment for oxygen and oxygen-related equipment based upon Medicaid's fee schedule. Such services are considered reasonable and necessary for participants with significant hypoxemia and certain related conditions. Refer to DME MAC coverage.

Exceptions are listed below. Signed physician's orders are required. A Certificate of Medical Necessity signed by the physician will be considered the same as a physician's order. Attaching the Certificate of Medical Necessity (CMN) will expedite claim processing. When billing electronically using the HIPAA Professional transaction, the oxygen information generally required on the CMN must be included on each claim.

The prescription and laboratory evidence justifying the use of oxygen must be included with the first claim for oxygen therapy for the participant. This prescription and laboratory evidence will be kept on file and will remain in effect for one year from the date the test was taken. All claims submitted electronically must include the oxygen information on each transaction.

Note: Oxygen, PRN or As-needed, are not acceptable prescriptions.

3.2.11.2 Exceptions to DME MAC Coverage

Age 0 — 6 Months

Lab studies are not required. Prior authorization is not required but must be a physician-ordered therapy and the initial claim must include Medical Necessity documentation or laboratory evidence.

Age 7 Months — 20 Years

Requires lab studies and Medical Necessity documentation. PA is not required except for conditions that do not meet lab study parameters.

3.2.11.3 Cluster Headaches

Medicaid may pay for oxygen for participants with a diagnosis of cluster headaches.

Note: Prior approval is required from Medicaid. Include the PA number on the claim. Lab studies are not required. PA requests must have physician orders that demonstrate the following medical necessity criteria:

- Other measures, such as Dehydroergotamine and Sumatriptan (Imitrex), have been tried and found to be unsuccessful.
- Oxygen therapy must have been proven successful on a trial basis for at least one treatment in the emergency room or in the physician's office before it can be authorized for home use.

If both criteria are met, authorization will be given for a six month period. Documentation of successful use and continued need must be received from the attending physician for subsequent PA.

If more than two months elapse without an incidence of a cluster headache, the oxygen authorization will be discontinued until the headaches start again.

When billing for oxygen that is necessary to treat cluster headaches:

- Bill with a paper claim.
- Attach a CMN indicating that the oxygen is *for cluster headaches*.

3.2.11.4 Documentation Requirements

The vendor must keep the following information in its files, in addition to documentation listed in *Section 3.2.3 Documentation Requirements*:

- Flow rate and oxygen concentration.
- Specific test results.

3.2.11.5 Ventilator Dependent Participants

Idaho Medicaid will authorize payment of oxygen and oxygen supplies and equipment when the participant is ventilator dependent. The participant does not have to meet the PO_2 level of 55 mm Hg or arterial oxygen saturation at or below 88 percent. The supplier must document on each claim that the participant is ventilator dependent. Enter in field **19** on the paper CMS-1500 claim form.

3.2.11.6 Payment Methodology

Idaho Medicaid pays for medically necessary oxygen with an all-inclusive monthly rate. This rate includes the rental of the delivery system and any necessary accessories such as flow valve, humidifiers, nebulizers for humidification, tubing, masks, contents for compressed gas and liquid systems, and nasal cannula/face masks.

In a limited number of cases, the participant owns the stationary or portable oxygen delivery system. Medicaid will pay to maintain such systems and pay a monthly charge for compressed gas and liquid systems. Medicaid will cover the cost of disposable items such as cannulas and tubing. The claim must document that the participant owns the system.

Note: All rentals must specify actual, inclusive dates of rental and must be billed monthly.

3.2.11.7 Certificate of Medical Necessity

When billing with a paper claim form**,** it is not always necessary to include a copy of the oxygen *Certificate of Medical Necessity***;** but it can expedite payment. A copy of the form can be found in *Appendix D; Forms.*

Claims for oxygen services can be billed electronically without attachments. Oxygen information must be included on each claim for which services are billed.

Additional information regarding the required values can be found in the *Provider Electronic Solutions (PES) Handbook* in the *837 Professional – Service 3 section*.

3.2.12 Prosthetic/Orthotic Description

Medicaid will purchase or repair medically necessary prosthetic and orthotic devices and related services that artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by Medicaid. See *Section 3.2.3 Documentation Requirements* and DME MAC coverage criteria.

3.2.12.1 Program Requirements

Medical necessity documentation must be kept on file by the vendor for five years after the date of service.

The following program requirements will be applicable for all prosthetic and orthotic devices or services covered by Medicaid. The Medicaid program follows the criteria established in the *DME MAC Supplier Manual*:

- A replacement prosthesis or orthotic device may be covered if justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device.
- An individual who is certified or registered by the American Board for Certification in Orthotics and Prosthetics shall provide all prosthetic and orthotic devices that require fitting.
- All equipment that is purchased must be new at the time of purchase. Modification to existing covered prosthetic or orthotic equipment will be covered.
- Purchased prosthetic limbs shall be guaranteed to fit properly for three months from the date of service. Any modifications, adjustments, or replacements within three months are the responsibility of the provider that supplied the item at no additional cost to Medicaid or the participant.
- No more than 90 days shall elapse between the time the attending physician orders the equipment and the equipment is delivered to the participant.

3.2.12.2 Program Limitations

The following limitations shall apply to all prosthetic and orthotic services and equipment:

- No replacement will be allowed for prosthetic or orthotic devices within 60 months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and a replacement is ordered by the attending physician.
- Refitting, repairs or additional parts shall be limited to one per calendar year for all prosthetics and orthotics unless a documented major medical change has occurred to the limb and refitting is ordered by the attending physician.
- All refitting, repairs or alteration requests must have documented medical justification by the participant's attending physician.
- Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by Medicaid. Exceptions are:
    - Artificial eyes (coverage per DME MAC criteria).
    - Breast prosthesis; prefabricated (coverage per *DME MAC* criteria).
- Electronically powered or enhanced prosthetic devices are not covered.
- Corrective shoes or modification to an existing shoe owned by the participant are covered only when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot.
- Shoes and accessories such as mismatched shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as a bandage following foot surgery, arch supports, foots pads, metatarsal head appliances or foot supports are **not** covered under the program.

- Corsets and canvas braces with plastic or metal bones are **not** covered. However, special braces enabling a participant to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast.
- Some AFOs that are not covered for adults may be covered for children. Use MAVIS or call EDS to check for age limitations.

3.3 Waiver Services

3.3.1 Covered Equipment and Supplies

The following may be covered under Waiver services.

- Environmental control devices, air cleaners/purifiers, dehumidifiers, portable room heaters or fans, heating or cooling pads.
- Wheelchair lifts for vans.
- Emergency response system services.
- Generators.
- Eating/feeding utensils, such as rocker knives, special plates with rims.
- Diverter valves for bathtub.
- Home improvements such as:
  - Timers.
  - Wheelchair lifts or ramps.
  - Electrical wiring.
  - Structural modification to the house as listed in *Section 3.3.3 Environmental/Home Modifications*.

Note: Waiver services are covered for Medicaid Enhanced Plan participants.

3.3.2 Assistive Technology

3.3.2.1 Overview

Assistive Technology (AT) is any item, piece of equipment, or product system beyond the scope of the Idaho Medicaid State Plan, whether acquired off the shelf or customized, that is used to increase, maintain, or improve the functional capability of the participant. Assistive technology items also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment. Items for recreational purposes are not covered.

All items shall meet applicable standards of manufacture, design and installation. The equipment must be the most cost effective to meet the participant's need.

3.3.2.2 Provider Qualifications

Providers must be enrolled as medical equipment vendors with the Medicaid Program.

3.3.2.3 Payment

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. Environmental modifications, van lifts and personal emergency response systems must be authorized by the Regional Medicaid Services (RMS) prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced Plan. The PA number must be included on the claim, or the service will be denied.

Other items must be submitted to the DME Unit for review. If the item cannot be covered under the State Plan, DME program, it may be considered under a waiver benefit, if it meets the criteria in *Section 3.3.2.1 Overview* and the participant is enrolled in the Medicaid Enhanced Plan. It must be the least costly means of meeting the needs of the participant. The request will be forwarded to the RMS Nurse Reviewer for authorization. The PA number must be included on the claim, or the service will be denied.

3.3.2.4 Procedure Codes

Service	Code	Description
Assistive Technology *A&D Waiver*	**E1399** Modifier **U2**	Assistive Technology, by report, amount authorized by Medicaid

3.3.2.5 Diagnosis Code

Enter the ICD-9-CM code for the participant's disability as the primary diagnosis - in field **21** on the CMS-1500 claim form or in the appropriate field of the electronic claim form, and **V604** - No Other Household Member Able to Render Care, as the secondary diagnosis.

3.3.2.6 Place of Service (POS) Codes

Assistive technology can only be provided in the following places of service:

12 Home

13 Assisted Living Facility

33 Custodial Care Facility

Enter this information in field **24B** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

3.3.3 Environmental/Home Modifications

3.3.3.1 Overview

Environmental/home modifications are interior or exterior physical adaptations to the home, required by the participant's Plan of Care, necessary to ensure the health, welfare, and safety of the individual. The modifications enable the participant to function with greater independence in the home and without which, the participant would require institutionalization.

Such adaptations may include:

- Installation of ramps and lifts.
- Widening of doorways.
- Modification of bathroom and kitchen facilities.
- Installation of electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant.

3.3.3.2 Exclusions

Exclusions are those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as:

- Carpeting.
- Repairs (roof, plumbing, electrical, etc.)
- Air conditioning.

3.3.3.3 Limitations

Permanent modifications are limited to modifications to a home owned by the participant or the participant's family when the home is the participant's principal residence.

Portable or non-stationary modifications may be made when such modifications can follow the participant to the next place of residence or be returned to DHW.

3.3.3.4 Provider Qualifications

Modification services must be completed with a permit or other applicable requirements of the city, county, or state in which the modifications are made. The provider must demonstrate that all modifications, improvements, or repairs are made in accordance with local and state housing, building, plumbing and electrical codes and/or requirements for certification.

3.3.3.5 Payment of Services

Medicaid reimburses waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid allowance. For medical equipment or retail items such as adaptive eating utensils or the chair portion of a lift chair, reimbursement will be 75 percent of the manufacturer's suggested retail price. Medicaid will reimburse for the least costly means of meeting the participant's need.

Rates for Waiver services that require a provider to have a license or certification will be negotiated. For home modifications, van lifts, etc., rates will be the cost of the service up to $500 or the lowest of three bids if the cost exceeds $500.

For A&D Waiver services, all home modifications must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced Plan.

For DD Waiver services, all home modifications must be authorized by the RMS prior to payment and must be the most cost-effective way to meet the needs of the participant. In addition, the participant must be enrolled in the Medicaid Enhanced Plan.

If PA is required, the PA number must be included on the claim, or the service will be denied.

3.3.3.6 Procedure Codes

Use the following 5-digit HCPCS procedure code when billing environmental modification services.

DD Services

Service	Code	Description
Environmental Modifications *DD Waiver*	**S5165** Modifier **U8**	Minimum age is 21. Services are authorized by the RMS. 1 Unit = 1 service.

A&D Waiver

Service	Code	Description
Home Modifications *A&D Waiver*	**S5165** Modifier **U2**	Home Modifications. Services are authorized by the RMS based on bid.

3.3.3.7 Diagnosis Code

Enter the ICD-9-CM code for the participant's disability – in the primary diagnosis in field **21** on the CMS-1500 claim form, or in the appropriate field of the electronic claim, and **V604** - No Other Household Member Able to Render Care, for the secondary diagnosis.

3.3.3.8 Place of Service (POS)

Environmental/home modification services can only be provided in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

3.3.4 Personal Emergency Response System (PERS)

3.3.4.1 Overview

Personal emergency response systems are provided to monitor the participants' safety and/or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. Personal emergency response systems are limited to participants who are enrolled in the Medicaid Enhanced Plan and who:

- Rent or own their home.
- Are alone for significant parts of the day.
- Have no regular caretaker for extended periods of time.
- Would otherwise require extensive routine supervision.

3.3.4.2 Provider Qualifications

Providers of PERS must demonstrate that the devices installed in participant's home meet Federal Communications Commission standards, Underwriter's Laboratory standards, or equivalent standards. Providers must be able to provide, install, and maintain the necessary equipment and operate a response center capable of responding on a 24-hour a day, 7-day per week basis.

3.3.4.3 Payment

Medicaid reimburses Waiver services on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All PERS services must be authorized prior to payment and must be the most cost-effective way to meet the minimum medical needs of the participant. If PA is required, the PA number must be indicated on the claim, or the service will be denied.

3.3.4.4 Procedure Codes

All claims must use one of the following 5-digit HCPCS procedure codes when billing PERS.

DD Services

Service	Code	Description
Initial Installation Fee *DD Waiver*	**S5160** Modifier **U8**	Only one installation fee is allowed for each participant per residence. This fee includes the installation fee and the first month's service fee. Minimum age is 21. 1 Unit = 1 service
Monthly Service Fee *DD Waiver*	**S5161** Modifier **U8**	This code can be billed only once per calendar month, and does not include the costs of monthly telephone service. Minimum age is 21. 1 Unit = 1 month

A&D Services

Service	Code	Description
Initial Installation Fee *A&D Waiver*	**S5160** Modifier **U2**	Initial installation fee, one time only per residence, paid by report based on amount authorized by RMS.
Monthly Service Fee *A&D Waiver*	**S5161** Modifier **U2**	Monthly service fee 1 Unit = 1 month

3.3.4.5 Diagnosis Code

Enter the ICD-9-CM code for the participant's disability – in field **21** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form and **V604 -** No Other Household Member Able to Render Care, as the secondary diagnosis.

3.3.4.6 Place of Service (POS) Code

PERS services can only be billed in the following POS:

12 Home

Enter this information in field **24B** on the CMS-1500 claim form, or in the appropriate field of the electronic claim form.

3.3.5 Specialized Medical Equipment and Supplies

3.3.5.1 Overview

Specialized medical equipment and supplies include devices, controls, or appliances, specified in the Individual Service Plan (ISP). The equipment and supplies must enhance the participant's daily living and enable the participant to control and communicate within his or her environment. This also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid program.

Items covered under the DD waiver are in addition to any medical equipment and supplies furnished under the Medicaid Basic Plan and exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items available under the Medicaid Basic Plan must be billed by a DME provider. A participant must be enrolled in the Medicaid Enhanced Plan to be eligible for items covered under the DD Waiver Program.

3.3.5.2 Provider Qualifications

Providers must demonstrate that the specialized equipment and supplies purchased under this service meet applicable standards of manufacturer, design and installation, including Underwriter's Laboratory (UL), Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards.

Specialized equipment must be obtained or provided by authorized dealers of the specific product when applicable (medical supply businesses or organizations that specialize in the design of the equipment).

3.3.5.3 Payment of Services

Rates will be determined by Medicaid on a case-by-case basis. (See costing and prior authorization guidelines for Targeted Service Coordinators for Durable Medical Equipment and Supplies available through the ACCESS units). If PA is required, the PA number must be included on the claim, or the service will be denied.

3.3.5.4 Procedure Codes

All claims must use the following 5-digit HCPCS procedure code when billing.

DD Services

Service	Code	Description
Specialized Medical Equipment/Supplies and Service *DD Waiver*	**E1399** Modifier **U8**	1 Unit = 1 service

3.3.5.5 Place of Service (POS)

Specialized medical equipment and supply services can only be billed with the following POS:

12 Home

99 Community

Enter this information in field **24B** on the CMS-1500 (claim form, or in the appropriate field of the electronic claim form.

3.4 Claim Billing

3.4.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

Note: All claims must be received within 12 months (365 days) of the date of service.

3.4.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software. See *Section 2.2.1, Electronic Claims Submission, General Billing Information,* for more information.

3.4.2.1 Guidelines for Electronic Claims

Provider Number: In compliance with HIPAA and the National Provider Identifier (NPI) initiative beginning May 24, 2008, federal law requires the submission of the NPI number on all electronic 837 transactions. Idaho Medicaid recommends providers obtain and register one NPI for each Medicaid provider number currently in use. It is recommended that providers continue to send both their Idaho Medicaid provider number and their NPI number in the electronic 837 transaction. Electronic 837 claims will not be denied if the transaction is submitted with both the NPI and the Idaho Medicaid provider number.

Detail lines: Idaho Medicaid allows up to fifty detail lines for electronic HIPAA 837 Professional transactions.

Referral number: A referral number is required on an electronic HIPAA 837 Professional transaction when a participant is referred by another provider. Use the referring provider's 9-digit Medicaid provider number, unless the participant is a HC participant. For HC participants, enter the provider's 9-digit HC referral number.

Prior authorization (PA) numbers: Idaho Medicaid allows more than one PA number on an electronic HIPAA 837 Professional transaction. A PA number can be entered at the header or each detail of the claim.

Modifiers: Up to four modifiers per detail are allowed on an electronic HIPAA 837 Professional transaction.

Diagnosis codes: Idaho Medicaid allows up to eight diagnosis codes on an electronic HIPAA 837 Professional transaction.

National Drug Code (NDC) information with HCPCS and CPT codes: A corresponding NDC is required on the claim detail when medications billed with HCPCS codes are submitted. See *Section 3.18.6.3 of the Physician Guidelines,* for more information.

Electronic crossovers: Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.4.2.2 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2006 is entered as 07042006

3.4.2.3 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form
- Print legibly using black ink or use a typewriter
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field
- Keep claim form clean; use correction tape to cover errors
- Enter all dates using the month, day, century, and year (MMDDCCYY) format; note that in field **24A** (From and To Dates of Service) there are smaller spaces for entering the century and year; Refer to specific instructions for field **24A**
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span
- A maximum of six line items per claim can be accepted; if the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements; total each claim separately
- Be sure to sign the form in the correct field; claims will be denied that are not signed unless EDS has a signature on file
- Do not use staples or paperclips for attachments; stack the attachments behind the claim
- Do not fold the claim form(s); mail flat in a large envelope (recommend 9 x 12)
- Only one prior authorization number is allowed for paper claims
- When billing medications with HCPCS/CPT codes, an NDC Detail Attachment must be filled out and sent with the claim

3.4.2.4 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
PO Box 23
Boise, ID 83707

3.4.2.5 Completing Specific Fields of CMS-1500

Consult the, Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid Program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

The following numbered items correspond to the CMS-1500 claim form.

Note: Claim information should not be entered in the shaded areas of each detail unless specific instructions have been given to do so.

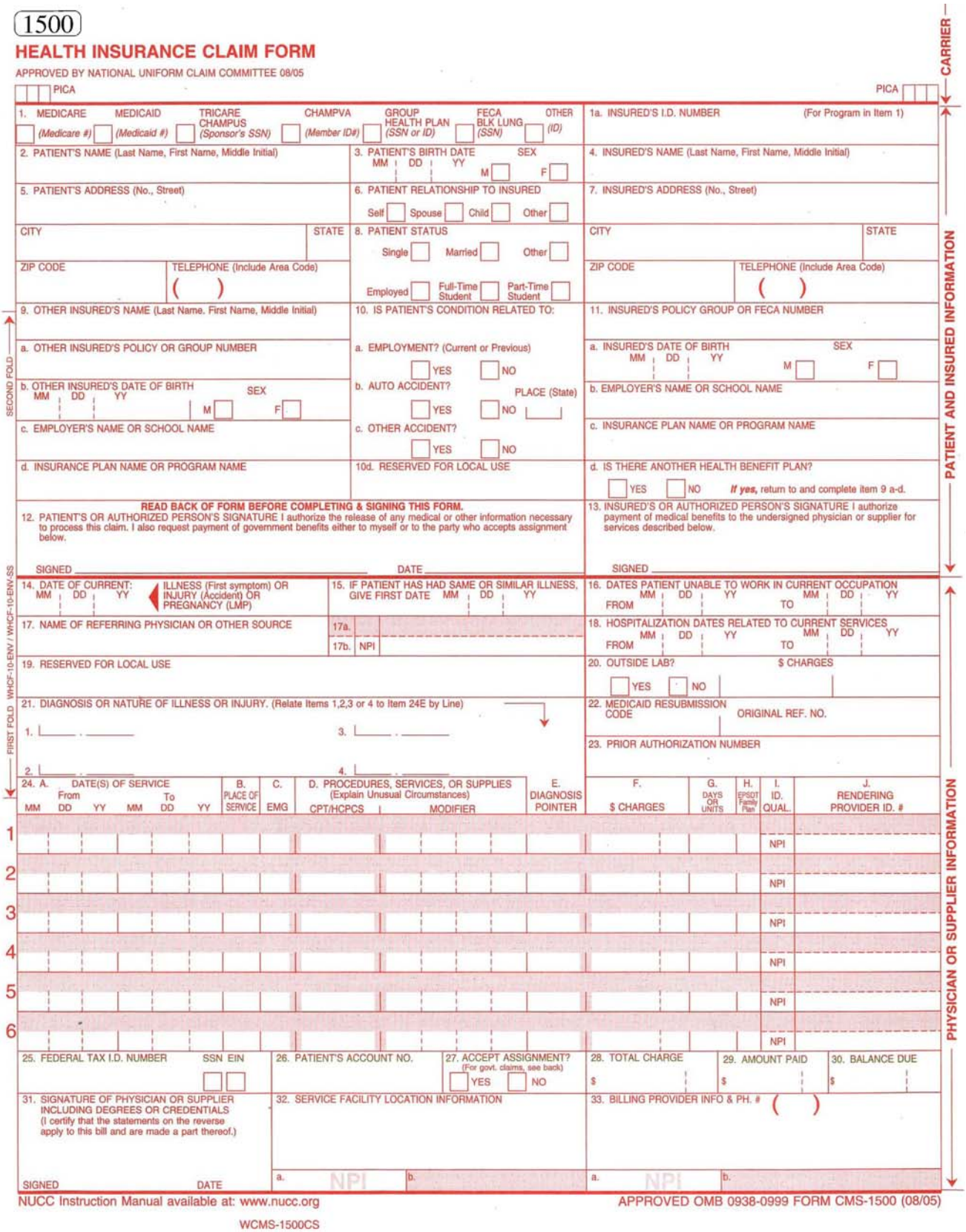
Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the participant's 7-digit Medicaid Identification (MID) number exactly as it appears on the MAID card.
2	Patient's Name	Required	Enter the participant's name exactly as it is spelled on the MAID card. Be sure to enter the last name first, followed by the first name and middle initial.

Field	Field Name	Use	Directions
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable	Required if field **11d** is marked yes.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field **11d** is marked yes. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate Yes or No, if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate Yes or No, if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate Yes or No, if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check Yes or No, if there is another health benefit plan. If yes, return to and complete items **9a-9d**.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	Other ID	Required if applicable	Use this field when billing for consultations or HC participants. For consultations enter the qualifier **1D** followed by the referring physician's 9-digit Idaho Medicaid provider number. For HC participants, enter the qualifier **1D** followed by the 9-digit HC referral number. **Note**: The HC referral number is not required on Medicare crossover claims.
17b	NPI Number	Not Required	Enter the referring provider's 10-digit NPI number. **Note:** The NPI number, sent on paper claims, will not be used for claims processing.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to four) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	If applicable, enter the PA number from Medicaid, DHW, RMS, ACCESS, RMHA, QIO, or MT.

Field	Field Name	Use	Directions
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24C	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24D 1	Procedure Code Number	Required	Enter the appropriate five character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Desired	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as four. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field **21**.
24F	Charges	Required	Enter the usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, see *Section 1.6 EPSDT*, for more information.
24I	ID. Qualifier	Required if Legacy ID	Enter qualifier **1D** followed by the 9-digit Idaho Medicaid provider number in **24J**.
24J	Rendering Provider ID Number	Required if applicable	Enter the 9-digit Idaho Medicaid provider number in the shaded portion of this field if the **1D** qualifier was entered in **24I**. **Note:** If the billing provider number is a group, then paper claims require the 9-digit Idaho Medicaid provider number of the performing provider in the Rendering Provider ID Number field. **Note:** Taxonomy codes and NPI numbers, sent on paper claims, will not be used for claims processing.
28	Total Charge	Required	Add the charges for each detail line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance including Medicare. Attach documentation from an insurance company showing payment or denial to the claim.
30	Balance Due	Required	Balance due equals the total charges less the amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See *Section 1.1.4 Signature- on- File Form,* for more information.
33	Provider Name and Address	Required	Enter the name and address exactly as it appears on the provider enrollment acceptance letter or RA. **Note:** If you have had a change of address or ownership, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33A	NPI Number	Desired but not required	Enter the 10-digit NPI number of the billing provider. **Note:** NPI numbers, sent on paper claims are optional and will not be used for claims processing.

Field	Field Name	Use	Directions
33B	Other ID	Required	Enter the qualifier **1D** followed by the provider's 9-digit Idaho Medicaid provider number. **Note:** All paper claims will require the 9-digit Idaho Medicaid provider number for successful claims processing.

3.4.2.6 Sample Paper Claim Form



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? PLACE (State) YES NO

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH. #

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS